BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

GARY C. BOLGAR, M.D.

Holder of License No. 11023
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-02-0345

CONSENT AGREEMENT FOR LETTER OF REPRIMAND

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Gary C. Bolgar, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that by entering into this Consent Agreement, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

3. Respondent acknowledges and understands that this Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Respondent acknowledges and agrees that, although the Consent Agreement has not yet been accepted by the Board and issued by the Executive Director, upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. Respondent further understands that this Consent Agreement, once approved and signed, is a public record that may be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

7. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

Gary C. Bolgar, M.D.

DATED: September 4 2013

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FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 11023 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0345 after being notified of a malpractice settlement regarding Respondent's care and treatment of a 45 year-old female patient ("E.P.").

4. On July 26, 1995, Respondent performed a vaginal hysterectomy on E.P. at Quincy Hospital ("Hospital"), in Quincy, Massachusetts.. During this surgery Respondent performed a procedure identified in the operative report as a "Burch colposuspension" ("Burch"). In conjunction with the surgery, Respondent catheterized E.P. The vaginal hysterectomy and Burch procedure were uneventful.

5. On July 30, 1995, E.P. had some leakage around the suprapubic tube, but after she urinated a residual volume of 400 cc, the suprapubic tube was removed. E.P. was observed for several hours prior to being discharged.

6. On August 3, 1995, E.P. presented to Respondent with complaints of inability to urinate. Respondent examined and assessed that E.P. needed to have a Foley catheter inserted because of her inability to urinate and leakage through the suprapubic tube site.

7. On six separate occasions, August 28, 1995, September 12, 1995, December 18, 1995, January 2, 1996, February 21, 1996 and April 17, 1996, E.P. presented to Respondent with complaints of discomfort, burning, frequent urination and, on one occasion, incontinence. Respondent stated he treated E.W.'s symptoms as

consistent with her documented 13-year history of urethritis. Respondent indicated that E.P.'s symptoms virtually resolved with antibiotic treatment so he did not consider the potential of an infection due to a foreign body.

8. In September, 1996, E.P. consulted another physician ("Physician"). Physician ordered diagnostic tests that revealed a retained segment of catheter inside E.P. Physician referred E.P. to another physician for another surgical procedure to remove the foreign body.

9. On October 4, 1996, the retained segment of catheter that remained in E.P.'s bladder was removed surgically. The operative note described the segment of catheter as a foreign object that was apparently the sheath of a suprapubic catheter.

10. Respondent stated that when he performed the Burch procedure on E.P., he employed a Bonnano brand suprapubic bladder drainage catheter. Respondent indicated that in previous procedures, he had routinely used Dow Corning's Cystocath, which was in short supply at the time of E.P.'s surgery on July 26, 1995.

11. Respondent stated that the other brands of suprapubic bladder drainage catheters he was familiar with had sheathes of contrasting colors. The Bonnano brand had a transparent sheath and a narrow flange. Respondent indicated that in the course of the procedure the sheath migrated into E.P.'s bladder without notice. Respondent admitted he had not identified the sheath and, therefore, did not remove the sheath prior to surgery. Respondent further stated that the sheath had not been separately identified pre-operatively and the catheter itself was accounted for at the close of surgery so the non-removal of the sheath went unnoticed.

12. Respondent stated he is more inclined to use a cystoscope on patients who experience similar symptoms following bladder suspension procedures and he pays

particular attention to the presence of sheathes in the small number of cases that he uses a suprapubic catheter.

13. The standard of care required Respondent to be fully acquainted with the use of surgical devices prior to surgical procedure and to appropriately investigate the cause of continuous postoperative complaints.

14. Respondent failed to meet the accepted standard of care because he used a surgical device that he was not fully acquainted with a nd because he failed to investigate the cause of continuous postoperative complaints.

15. E.P. was harmed because the sheath remained in her bladder, after the catheter was removed, causing postoperative urinary burning, frequency and incontinence and because she was required to undergo additional surgery to remove the sheath.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(ll) - ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for his failure to use a surgical device properly and for his failure to respond to the patient's repeated complaints postoperatively, which caused a delay in diagnosing a retained foreign body.

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2. This Order is the final disposition of case number MD-02-0345.

DATED AND EFFECTIVE this 10th day of October, 2003.

(SEAL)

ARIZONA MEDICAL BOARD

By Barry A. Cassidy
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 10th day of October, 2003 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 10th day of October, 2003 to:

Paul R. Cirel
Dwyer & Collera, LLP
600 Atlantic Avenue
Boston, Massachusetts 02210-2211

EXECUTED COPY of the foregoing mailed by Certified Mail this 10th day of October, 2003 to:

Gary C. Bolgar, M.D.
2110 Dorchester Avenue, Suite 308
Dorchester, MA 02124-5628

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EXECUTED COPY of the foregoing hand-delivered this 10th day of October, 2003, to:

Christine Cassetta, Assistant Attorney General
Sandra Waitt, Management Analyst
D.K. Keenom, Division Chief, Enforcement
Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Board Operations